STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	07/13/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILTON & HATTIE KUTZ HOME	704 RIVER ROAD WILMINGTON, DE 19809

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F 000	INITIAL COMMENTS Revised report as of 9/17/2009 following IDR request. Example removed from F 309. No change in scope and severity. An unannounced QIS annual survey was conducted at this facility from July 6, 2009 through July 13, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 87. The survey sample totaled 91 residents, which included 40 census residents, 20 admission residents and 31 stage 2 residents.	F 000		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour on 7/6/09 through 7/10/09, and staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary interior. Findings include: 1. The oxygen concentrator filters in resident rooms 502, 505, 604A were observed with heavy thick dust. Interview with nursing staff (E2) revealed the facility nursing staff is supposed to clean them. 2. Throughout the survey, an offensive odor was detected in the 600 unit lounge of the facility.		**F 253** Example #1 1. No resident was affected by this practice. 2. All resident oxygen concentrators were audited by nursing to ensure compliance with cleanliness of filters, tubing, and humidifier changes. 3. The shift supervisor checklist has been revised to include compliance with filter cleanliness, tubing, and humidifier changes. Respiratory Therapy Associates (RTA) will continue to perform monthly maintenance program of concentrators. An in-service to all nursing staff will be completed by 8/23/09. (see attached checklist) 4. The Oxygen tracking sheet will be utilized to audit weekly compliance. (see attached) **8/23/09**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

EXECUTIVE DIRECTOR | REVISED 9/30/09

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F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations during the environmental tour on 7/6/09 through 7/10/09, and staff interviews, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary interior. Findings include: 1. The oxygen concentrator filters in resident rooms 502, 505, 604A were observed with heavy thick dust. Interview with nursing staff (E2) revealed the facility nursing staff is supposed to clean them. 2. Throughout the survey, an offensive odor was detected in the 600 unit lounge of the facility.	F 253	Example #4 1. No resident was affected by this practice. 2. All chairs were checked for proper condition and repaired or discarded as necessary 3. CNA's will now utilize the rounds worksheet for maintenance concerns. An in-service to all nursing staff will be completed by 8/23/09(see attached worksheet) 4. The nursing supervisor will review the rounds worksheet and complete work order forms as needed. The charge nurse will utilize the shift supervisor report sheet as an audit tool for nursing administration to monitor completion. Monthly safety rounds will be completed to ensure compliance. (see attached) **8/23/09** Example #5 1. The rugs and floors in this area have been cleaned. 2. All carpet and vinyl flooring have been checked for spots and cleaned. The floor care program has been modified to increase the carpet cleaning to weekly. (Carpeting in lounges and other public areas is on schedule to be replaced within the next six months) 3. Staff has been in-serviced on the use of the work order system to alert the responsible department in the event of spills, etc. Work Orders are checked a minimum of 4 times per day. 4. AM and PM inspections are in place for Housekeeping and Maintenance Departments to tour the facility, including floors (see attached) **7/14/09**	

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F 253	Continued From page 1 3. On 7/9/09 at 11:00 AM, the laundry washer hose was leaking and a puddle of water was observed on the floor of the laundry area. Staff (E8) confirmed this finding. 4. On 7/6/09 at 9:40 AM, a brown Geri chair left arm rest upholstery was in disrepair and uncleanable in the 600 unit lounge. The wheelchair of resident room 506B had food debris on the foot rest area. 5. On 7/10/09 at 1:30 PM, floor rugs were observed stained in the 300 and the 500 unit hallways. The floor of resident room 103 was stained.	F 253		
F 254 SS=C	483.15(h)(3) ENVIRONMENT- LINENS The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to have available sufficient towels and wash clothes in the 100, 400 and 500 units clean linen storage closets for residents' showers. On 7/9/09 at 10:10 AM, an announcement over the loud speakers indicated the staff had no towels in the 100 unit for resident showers. On 7/9/09 at 10:20 AM, observations of the 100 and 400 unit clean linen storage closets revealed no towels and wash clothes on the floors for resident showers. Unit 600 had five towels and no wash clothes. Nursing staff interview (E2) confirmed this finding.	F 254	**F 254** 1. Additional towels and wash cloths have been purchased 2. All linens have been inventoried, and additional linens have been purchased, received, and are available for distribution 3. Par levels have been reviewed by Nursing staff and increased to meet the needs of the residents; separate locked linen closets have been established in each unit to ensure that the proper amount of linens is available for each shift (see attached Policy and par Level checklist) 4. Daily inspections of each closet and linen requisition forms are in place to ensure par levels are met; Nursing, Housekeeping and Laundry staff has been in-serviced on proper protocols and use of the linen par system (see attached) **8/10/09**	

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F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Cross refer to F279 Based on record review and interview, it was determined that the facility failed to conduct a periodic comprehensive assessment for R52's	**F 272**	1. MDS coordinator completed an annual MDS on resident R 52 on 7/11/09. A Care plan was completed on 7/11/09 for mood and behavior. (see attached) 2. An MDS/Care plan audit was completed for all residents on 7/20/09. The audit focused on the completion and accuracy of information. 3. The 24-hour report sheet has been revised to include behaviors and any mental status changes. An in-service will be provided to reflect the updated 24-hour report sheet by 8/23/09. The care plan nurse will review the 24-report sheet daily for any changes and will update care plans accordingly. (see attached) 4. The RNAC will utilize the MDS/Care Planning Tracking log to ensure completion. (see attached) The MDS/care plans will be audited on a weekly basis. The audits will be completed according to the care conference schedule to ensure accuracy and completion. (see attached) **8/23/09**	

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F 272	Continued From page 3 mood and behavior patterns. The facility failed to have a quarterly MDS assessment for April 2009 that addressed resident R52's mood and behavior pattern status. Findings include: On 7/9/09, review of social service director (E7) notes indicated that the resident had emotional concerns that needed to be addressed. Record review lacked evidence of an MDS assessment for April 2009 for R52 the last quarterly MDS was done in January 2009. A care plan was not completed for resident R52's mood and behavior pattern status On 7/10/09, findings were confirmed with the acting ADON (E3). She stated that she could not find a MDS for this resident and therefore there was none. A search for the MDS document was conducted without success for this resident.	F 272	**F 279** 1. A Care plan was completed on 7/11/09 for mood and behavior for resident R 52. 2. An MDS/Care plan audit was completed for all residents on 7/20/09. The audit focused on the completion and accuracy of information. 3. The 24-hour report sheet has been revised to include physical, behavioral and any mental status changes. An in-service will be provided to reflect the updated 24-hour report sheet by 8/23/09. The care plan nurse will review 24-report sheet daily for any changes. (see attached) 4. The care plans will be audited on a weekly basis. The audits will be completed according to the care conference schedule to ensure accuracy and completion. (see attached) **8/23/09**	
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided			

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F 279	Continued From page 4 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that one (1) resident (R52) had a care plan that included all of her current assessed needs such as mood and behavior patterns. Findings include: Review of R52's clinical record lacked evidence that a care plan for behavior and emotional needs was developed. While the facility care planned for psychotropic drugs there was no actual care plan for mood and behaviors. Acting ADON (E3) interview on 7/10/09 confirmed this finding.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280		

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F 280	Continued From page 5 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to review and revise the care plans for five (5) out of 31 stage 2 sampled residents (R16, R58, R45, R100 and R48). Findings include: 1. Resident R16 was initially admitted to the facility on 09/10/2008 with a reentry date of 05/18/2009 following a hip fracture. Additional diagnoses for this resident included abdominal pain, constipation, urinary tract infection, hypertension and dementia. The MDS (Minimum Data Set) dated 05/25/2009 stated that R16 was cognitively impaired and was totally dependent upon staff for all ADLs (activities of daily living). This 5 day Medicare assessment and the 14 day Medicare assessment dated 05/28/2009 MDS stated there were no pressure ulcers present. The MDS (30 day Medicare assessment) dated 06/07/2009 stated the resident had 4 (should have been a 1) stage 4 pressure ulcers. The nurses's note dated 06/03/2009 and timed 8 PM noted on right heel a 5 cm by 4 cm dark blister with skin intact. The doctor was notified and among the orders dated 06/03/2009 included treatment with skin prep to the right heel, elevate heels from bed and to use heel protectors. The	F 280	1. Care plans for residents R 16, R 58, R 45 and R 48 were reviewed and revised by 7/15/09. Resident R100 was discharged from the facility on 7/31/09. (see attached) 2. An MDS/Care plan audit was completed for all residents on 7/20/09. The audit focused on the completion and accuracy of information. 3. The 24-hour report sheet has been revised to include physical, behavioral and any mental status changes. An in-service will be provided to reflect the updated 24-hour report sheet by 8/23/09. The care plan nurse will review 24-report sheet daily for any changes. (see attached) 4. The care plans will be audited on a weekly basis. The audits will be completed according to the care conference schedule to ensure accuracy and completion. (see attached) 8/23/09	

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F 280	Continued From page 6 07/01/2009 physician orders repeated these orders. While the facility developed a care plan (CP) dated 07/05/2008 for (Pressure Ulcers) the potential for alteration in skin integrity r/t decreased mobility and occasional incontinence the care plan only included the approaches to use heel protectors when in bed but failed to include offloading of the heels. Review of the physician's orders dated 06/19/2009 and 07/01/2009 stated to elevate the heels from the bed. Additionally the care plan was never updated to reflect the development of an actual unstageable pressure ulcer. 2. R58 was admitted to the facility on 01/09/06 with diagnoses which included left cerebrovascular accident(CVA), aphasia, hemiplegia/hemiparesis and glaucoma. The admission Minimum Data Set (MDS) dated 01/20/06 reflected these diagnoses and also listed the following limitations. There was a limitation in range of motion on one side of the body and a partial loss of voluntary movement of the arm and hand. The annual assessment of 11/28/2008 under range of motion also stated limitation of one side of the body. Physical Therapy evaluation and treatment notes dated 12/31/2008 stated resident evaluated for positioning to prevent skin breakdown and further contracture. This document stated right upper extremity positioned on cushion covered material with Velcro straps. Review of the range of motion quarterly screening	F 280		

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F 280	Continued From page 7 by physical therapy dated 05/04/2009 stated the resident had limited range of motion of the right foot and knee and limited range of motion of the right fingers. The facility developed a care plan for the problem (ADL Function/Rehab Potential) self-care deficit related to left sided CVA with right hemiparesis, aphasia and depression. The approaches developed failed to be revised to include any interventions to prevent further contracture of the hand and failed to include instructions regarding right upper extremity positioning. 3. Review of the clinical record for R45 revealed that this resident was receiving Trazodone at bedtime. The facility developed a care plan dated 11/29/2007 for (psych-soc/psychotropic drug use) Psychotropic medication usage related to dementia, depression, anxiety. The care plan did not include the problem of insomnia. Additionally review of the approaches listed on this plan failed to include any non pharmalogical approaches to be used prior to or in conjunction with medication for R45. 4. Review of the clinical record for R100 revealed that this resident had a care plan dated 04/14/2009 for a problem psychosocial well being due to life change. The approaches listed failed to be revised to include issues revealed in facility documentation and staff interview. Review of social service notes dated 04/13/2009 stated R100's husband died suddenly last week. Interview with E19(Facility nurse) on 07/10/2009 at 3 PM confirmed that the care plan was not	F 280		

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F 280	Continued From page 8 revised to include the resident's concerns about the delay in dart bus service to her dialysis appointments, husband's death, panic attacks, crying and behaviors while at the facility. Cross refer F281 Ex #2. 5. Review of R48's clinical record revealed a care plan dated 7/15/08 and entitled, "(Dehydration/Fluid Maintenance) Potential for dehydration r/t (related/to) diuretic usage." R48 was re-admitted to the facility, post hospitalization, on 4/14/09 for syncope secondary to hypotension and dehydration. Although the facility had developed a care plan for R48, it failed to review and revise this care plan from a potential problem to be an actual problem and add or change any interventions necessary to ensure the resident's safety and well-being. During an interview on 7/10/09 with E12, a staff nurse and E4, the infection control nurse, confirmed that R48's careplan was neither updated nor revised upon the resident's return to the facility.	F 280		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of clinical record and facility policies and interview, it was determined that the facility failed to meet the professional standard of practice for one resident, R80, out of 31 stage 2 sampled residents. The facility failed to follow their medication administration procedure when they allowed one resident (R80) to self administer her own meds without a physician's order. Findings include:	F 281		

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F 281	Continued From page 9 R80 was admitted to the facility with diagnoses that included depression. Review of R80's Quarterly Minimum Data Set (MDS), dated 4/10/09, revealed this resident's cognitive skills for decision making were assessed as "modified independence" with short term memory problems. On 7/10/09 at 10:20 AM, R80 was observed requesting assistance at the 400 Wing nurse's station, stating, "I dropped my pink pill." E12, a staff nurse, went into the resident's room and found a dark green pill under R80's bed & stated that it was R80's "iron pill". E12 wasted the medication and gave R80 another iron pill from the med cart. During an interview on 7/10/09 at 10:30 AM, R80 stated that her meds had been left on her nightstand in a medicine cup next to her water. R80 confirmed that "lately" this was the way her pills were left for her. During an interview on 7/10/09 at 10:35 AM, E12 confirmed that she had "popped out" R80's meds and put them in a cup at her bedside & that the resident takes them after she finishes her breakfast. E12 denied that R80 had a physician order to self-administer meds. Review of the MAR, reveals that R80 is monitored for "panic" & "Paranoia" behaviors. Documentation on the 7/09 MAR revealed that 9 AM medications given to R80 included Calcitriol (Vitamin D3), Centrum silver tab (multivitamin), Paxil (used to treat depression and panic disorder), magnesium oxide (magnesium supplement), Lopressor (used to treat high blood pressure), calcium antacid, and Ferrous Sulfate (iron supplement).		**F 281** 1. The resident was not adversely affected by this practice. 2. Nurse E 12 has been individually educated and counseled on proper medication administration protocols. 3. Nurses will attend a Medication Pass in-service including Infection Control by 8/23/09. Each nurse will complete a Clinical Care competency test by 8/23/09. (see attached) 4. Nursing administration will complete random medication pass monitoring utilizing the Medication Administration audit tool. This will be done on an annual basis and as needed with the results submitted to the QA meeting. (see attached) **8/23/09**	

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F 281	Continued From page 10 Review of the 7/09 Physician's Order Sheet (POS) and physician's orders revealed that there was no order for R80 to self-administer her own meds. Review of the facility policy entitled, "Medication Administration-General Guidelines" stated, " ...B. Administration ... Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications ... The resident is always observed after administration to ensure that the dose was completely ingested ..." The facility staff failed to follow professional standards for administering medications, by failing to observe R80 ingesting her medication and allowing the resident to self administer her meds without a physician's order.	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, resident observation, staff interviews, review of other facility documents, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being for three (3) out of 30 sampled residents (Residents	F 309		

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F 309	Continued From page 11 R48, R68 and R93) in accordance with their assessments and plans of care. The facility failed to implement the interventions listed on the care plans for two residents (R48 & R68) who were at risk for dehydration. Findings include: 1. Review of R48's clinical record revealed a care plan dated 7/15/08 and entitled, "(Dehydration/Fluid Maintenance) Potential for dehydration r/t (related/to) diuretic usage." One of the approaches listed for this potential problem included, "Monitor for s/s (signs/symptoms) of dehydration (poor skin turgor, decreased urine output, change in mental status, dry mucous membranes). Review of R48's clinical record lacked evidence of monitoring for s/s of dehydration. During an interview on 7/9/09, E12, a staff nurse, confirmed that there was no documentation for this approach. E12 stated that a physician's order was needed in order to monitor I&Os (Intake & Output). During an interview on 7/10/09, E17, the Medical Director, stated that he would expect the facility to monitor residents who were at risk for dehydration, for example, what the resident ate and drank, monitoring weight status, etc. E17 stated that a physician might choose to order I&Os but staff are not limited from initiating I&Os themselves ... they "do not need an order to do that.. each resident is treated individually." He would expect that staff would alert him of any changes such as increased lethargy, weight changes, decreased appetite, decreased overall energy... E17 confirmed that when R48's status changed from a "potential" risk for dehydration to an "actual" diagnosis of dehydration, that the facility should have updated the problem and approaches on the care plan.		**F 309** Examples #1 and #2 1. After review of the residents R 48 and R 68 and their records, it was determined that I and O's were not necessary due to stability of medical condition. Care plans for those residents were revised. (see attached) 2. All residents will be reviewed for intake by utilizing the revised meal consumption record. (see attached) 3. An in-service will be provided for the nursing staff on the meal consumption record and signs and symptoms of dehydration. Any resident on diuretic therapy will be monitored every shift for signs and symptoms of dehydration, and documented on the Medication Treatment Record. 4. In the event that an issue is identified, the charge nurse will document accordingly and request a dietician to consult. **8/23/09**	

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F 309	Continued From page 12 During an interview on 7/10/09 with E12, a staff nurse and E4, the infection control nurse, confirmed that there was no evidence in the clinical record regarding R48's skin turgor, mucous membranes, etc. The facility failed to implement their listed approach on R48's care plan for monitoring for s/s of dehydration. 2. Review of R68's clinical record reveals that this resident was at risk for dehydration related to diuretic usage. A nutrition care plan dated 1/15/09 included approaches listed for this potential problem "Monitor labs, wts, intake inc. fluid intake". Review of R68's clinical record lacked evidence of monitoring fluid intake. During an interview on 7/9/09 with E20, the dietician, confirmed that there was no documentation for this approach. E20 stated that a physician's order was needed in order to monitor I&Os (Intake & Output). During a surveyor interview on 7/10/09 with E17, the Medical Director, stated that he would expect the facility to monitor residents who were at risk for dehydration, for example, what the resident ate and drank, monitoring weight status, etc. E17 stated that a physician might choose to order I&Os but staff are not limited from initiating I&Os themselves ... they "do not need an order to do that.. each resident is treated individually." He would expect that staff would alert him of any changes such as increased lethargy, weight changes, decreased appetite, decreased overall energy... 3. Observation and resident interview on 7/8/2009 at 8:40 AM revealed that resident R93 was very upset regarding the late breakfast tray. This resident complained "Why is my breakfast tray late every day... I am diabetic...sometimes	F 309	Example #3 1. The insulin schedule for resident R 93 was adjusted to accommodate his needs during breakfast per his request as discussed during a meeting with resident and family on 7/31/09. 2. All diabetic residents were reviewed by Nursing for timeliness between insulin administration and meal times. Dining Services staff was in-serviced on resident diets on 7/21/09 and importance of timely meals to residents with special needs (see attached in-service records). 3. Residents with special needs/diets are reviewed each day at daily pre meal meetings by the Executive Chef and or the lead cook. 4. Morning Dining Services tray line staff has been re-aligned and a "checker" has been put into place. The am supervisor is responsible for monitoring the timeliness and accuracy of the meal trays and delivery. **8/06/09**	

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F 309	Continued From page 13 feel faint..." Resident interview revealed that receiving the breakfast tray late is a constant problem, the resident has an Accuchek done at 6:30AM and gets an insulin injection about 1 hour later at 7:30AM. Resident is to receive breakfast at 8:00AM (1/2 hr after their insulin dose). Interview with the Medication Nurse confirmed that the Accuchek is done at 6:30AM, has a Doctor's order for sliding scale coverage, insulin is given at 7:30AM and breakfast is to be given 1/2 hr later at 8:00AM. Resident R93 received the breakfast tray at 8:45AM. Resident interview revealed that sometimes snack is needed if the breakfast tray is late to avoid feeling faint.	F 309		
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Cross refer to F441, F280 Based on record review, observation and interviews it was determined that the facility failed to prevent the development of a new pressure ulcer for one out of 40 census sampled residents (R16). Additionally the facility failed to ensure that interventions implemented were effective in off loading the heel of R16 who developed an unstageable pressure ulcer. Findings include:	F 314		

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F 314	Continued From page 14 Resident R16 was initially admitted to the facility on 09/10/2008 with a reentry date of 05/18/2009 following a hip fracture. Additional diagnoses for this resident included abdominal pain, constipation, urinary tract infection, hypertension and dementia. The MDS (Minimum Data Set) dated 05/25/2009 stated that R16 was cognitively impaired and was totally dependent upon staff for all ADLs (activities of daily living). This MDS (5 day Medicare assessment) and the 14 day Medicare assessment dated 05/28/2009 MDS stated there were no pressure ulcers present. The MDS (30 day Medicare assessment) dated 06/07/2009 stated the resident had 4 (should have been a 1) stage 4 pressure ulcers. The nurses's note dated 06/03/2009 and timed 8 PM noted on right heel a 5 cm by 4 cm dark blister with skin intact. The doctor was notified and among the orders dated 06/03/2009 included treatment with skin prep to the right heel, elevate heels from bed and to use heel protectors. The 07/01/2009 physician orders repeated these orders. The skin condition record dated 06/03/2009 identified one area on the right heel as an intact blister 5 cm X 4 cm with the wound bed dark in color and surrounding skin and tissue edges also dark. The weekly pressure ulcer record dated 06/16/2009 staged the right heel as unstageable with measurements of 5.5 cm X 4 cm wound bed black. The weekly pressure ulcer record dated 06/30/2009 listed under the preventative measures heel protectors and a foot cradle. While the facility developed a care plan (CP) dated 07/05/2008 for (Pressure Ulcers) the potential for alteration in skin integrity r/t decreased mobility and occasional incontinence	F 314	**F 314** 1. Care plan for resident R 16 was updated on 7/14/09. CNA care plan for R 16 was updated on 7/13/09. The resident's care plans now reflect positioning to include complete heel offloading in a geri recliner and in bed. The resident's wound continues to heal as evidenced by the eschar peeling away and new skin underneath pink and intact. Resident was subsequently diagnosed via a Doppler study conducted on 8/8/09, with bilateral femoral arterial occlusions (see attached). 2. A new CNA data sheet has been developed to communicate all residents' needs and devices. 3. Wounds will continue to be discussed during the Skin, Weight, Infection, Falls, Team (SWIFT) meetings. Documentation of skin checks on shower days will continue and will be reported to nurse. American Medical Technology will conduct a wound care in-service on 8/18/09. 4. The SWIFT team, along with wing charge nurses will conduct wound/skin care rounds on a weekly basis. During that time, the team will check for compliance of off loading and other preventative measures, as well as proper infection control technique. The findings will be included in the report at the monthly QA meeting. **8/23/09**	

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F 314	Continued From page 15 the care plan only included the approaches to use heel protectors when in bed but failed to include offloading of the heels. Review of the physician's orders dated 06/19/2009 and 07/01/2009 stated to elevate the heels from the bed. During Interview with the Physical Therapist (E15) on 07/09/2009 at 10:20 AM revealed that in addition to the boot being applied to the right heel, it was expected R16's heel would be elevated off of the bed via a foam device. However, this approach failed to be included on the resident's care plan. During an Interview with the nurse (E16) at 5:30 AM on 7/13/2009 it was revealed that the CNAs know what care to provide based on the CNA care plan. However the CNA CP also failed to include instructions regarding the foam device and off loading of the heels. Observations of R16 during the survey revealed the following: On 07/09/2009 at 8:40 AM Resident (R16) was observed in bed with a foam boot on the right heel. The boot had a hole in it for the heel to be placed in it but it was not applied in that manner. Although the foam boot was on the right heel was directly on mattress. The CNA (E14) removed the boot and the heel was observed to have a dark black necrotic area about the size of a half dollar. The resident positioned on her back with the heel resting on the bed. There was no foam cushion in place to elevate the heel. On 07/09/2009 at 8 PM Resident (R16) observed in bed with the foam boot on the right foot but the foam cushion to elevate the heels was not in place. While the boot was in place the heel still rested on the bed.	F 314		

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F 314	Continued From page 16 On 7/10/2009 at 8 15 AM R16 was observed in bed with the boot on the right heel with the foam cushion in place to off load the heel. On 7/13/2009 at 5:30 AM R16 was observed in bed with the left boot in the bed and not on her foot. The right boot was on the foot but the foot was resting on bed. There was no foam cushion in place. Interview with (E16) the nurse at 6:50 AM revealed that CNAs know what care to provide based on the CNA CP. However the CP just stated to have the boots in place and there was no mention of the foam cushion or off loading of the heels. Interview with the Inservice Director (E4), and the (E12) nurse caring for R16 on 7/13/09 at 7:15 AM reviewed positioning issues, lack of revised care plan and the development of a pressure ulcer for this resident who entered the facility without a pressure ulcer. The Inservice Director (E4) started inservices immediately following notification of the concerns for R16.	F 314		
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews it was determined that the facility failed	F 318		7/13/09

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F 318	Continued From page 17 to ensure that a resident with a limited range of motion receives appropriate treatment and services to prevent a further decrease in range of motion for one out of 40 census sampled residents (R58). Findings include: R58 was admitted to the facility on 01/09/06 with diagnoses which included left Cerebrovascular accident(CVA), aphasia, hemiplegia/hemiparesis and glaucoma. The admission Minimum Data Set (MDS) dated 01/20/06 reflected these diagnoses and also listed the following limitations. There was a limitation in range of motion on one side of the body and a partial loss of voluntary movement of the arm and hand. The annual assessment of 11/28/2008 under range of motion also stated limitation of one side of the body. Physical Therapy evaluation and treatment notes dated 12/31/2008 stated resident evaluated for positioning to prevent skin breakdown and further contracture. This document stated right upper extremity positioned on cushion covered material with velcro straps Review of the range of motion quarterly screening by physical therapy dated 05/04/2009 stated the resident had limited range of motion of the right foot and knee and limited range of motion of the right fingers. The facility developed a care plan for the problem (ADL Function/Rehab Potential) self-care deficit related to left sided CVA with right hemiparesis, aphasia and depression. The approaches developed failed to include any interventions to prevent further contracture of the hand and failed	F 318	**F 318** 1. Resident R 58 was placed on the Medicaid Maintenance Program for Range of Motion, but has consistently refused treatment from 8/4/09 to 8/11/09. The resident's care plan has been updated to reflect non-compliance. Resident R 58 will be approached quarterly to determine possible interest in treatment (see attached) 2. All residents were audited to ensure that therapy screens were completed and accurate. 3. A Range of Motion assessment is to be completed by the Rehabilitation department on a quarterly basis for all residents. Based on the ROM assessment, a rehabilitation screen will be initiated and residents evaluated for therapy services (see attached). 4. A Range of Motion log will be utilized by the Rehabilitation department as the audit tool to ensure that each resident is assessed on a quarterly basis. The Restorative Log will be utilized by the Care Plan nurse as the audit tool to ensure that residents are on appropriate programs. Both tools will be reviewed at the monthly QA meeting. (see attached) **7/31/09**	

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F 318	Continued From page 18 to include instructions regarding right upper extremity positioning. Observations of R58 on 07/09/2009 and 07/10/2009 revealed right upper extremity not positioned on elevated wedge of wheel chair. During an interview with the physical therapist (E15) on 07/10/2009 at 8:30 AM she stated the resident does not have contractures even though resident has limited range of motion. The therapist confirmed that R58 was not on a restorative program. Review of a document provided by E15 listing all residents receiving therapy confirmed that R58 was not on a restorative program. The facility failed to ensure that R58 received services to prevent a further decline of the right arm and fingers.			
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interview, it was determined that the facility failed to maintain an environment free from accident hazards as evidenced by isolated cases of resident water		**F 323** Example #1 1. No residents were affected by the deficient practice. 2. A new policy and procedure for hydrocollator machine locking will be put into place, where machine will be locked and un-locked at each use. The staff was in-serviced on new policy and procedure on 8-11-2009 (see attached). 3. A log has been posted next the hydrocollator and each staff member will need to check and sign after each use of the hydrocollator. The logs will be filed in Logbook along with hydrocollator temperature and cleaning schedule (see attached). 4. The Department Director will conduct weekly checks at random times for compliance. Compliance will also be monitored during monthly safety rounds **8/11/09** Example #2 1. An adjustment was made to the mixing valve to lower the hot water temperature to 110 degrees on 7/9/09 2. The entire facility was checked and found to be in compliance on 7/9/09 3. Daily spot checks of hot water temperature will continue be made throughout the facility by the Maintenance department 4. Daily recordings of hot water temperatures are logged; additionally, the Laundry staff will also record and monitor the hot water temperatures during the day.(see attached checklist) **7/14/09**	

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F 323	Continued From page 19 temperatures above 110 degrees Fahrenheit, chemicals and hydrocollator unlocked and accessible. Findings include: 1. On 7/9/09 at 3:50 PM, an unlocked hydrocollator with a temperature of 160 degrees Fahrenheit was observed in an unattended and unlocked physical therapy room. 2. On 7/9/09 at 8:46 AM, the hot water temperature in resident rooms 108 and 110 hand sinks were measured at 117 and 118 degrees Fahrenheit respectively. On 7/9/09 at 9:21 AM, the satellite dining room 100 hand sink (for 100 and 300 units) measured 117 degrees Fahrenheit. Maintenance staff (E8) interview revealed a minor adjustment was made to the boiler mixing valve setting. On 7/9/09 at 6:05 PM, temperatures in room 108 and satellite dining room were measuring 102 and 103 degrees Fahrenheit respectively. Interview with the maintenance staff (E8) on 7/10/09 indicated the hot water temperatures were measuring about 106 degrees Fahrenheit after an adjustment was made to the boiler hot water mixing valve. 3. On 7/9/09 at 10:20 AM, various bottles of resident personal soaps, shampoos were observed accessible to residents in two unlocked clean linen storage closets.	F 323	Example #3 1. No residents were affected by this practice. 2. Separate locked linen closets have been established in each unit, eliminating the use of the un-locked closets 3. Nursing staff will monitor the storage of personal hygiene items in resident rooms and public areas throughout the shift and document findings during shift change rounds (see revised checklist). Staff will be in-serviced on the revised form 4. Charge nurse is responsible to review all shift change rounds reports. Compliance will also be monitored during routine rounds and monthly safety rounds. **8/23/09**	
F 362 SS=E	483.35(b) DIETARY SERVICES - SUFFICIENT STAFF The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	F 362		

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F 362	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and meal schedules, it was determined that the facility failed to provide meals in a timely manner as evidenced by meals being served late and insufficient staffing. Findings include: On 7/6/09, observation of lunch service on the main dining room revealed that the meal was served up to 12:55 PM and showed only two servers serving the meals. Residents were observed arriving at the main dining room by 11:30 AM. The facility's "Meal Times" schedule for lunch stated the main dining room meal times to be between 11:45 AM and 12:15 PM. At 12:46 PM, four tables were observed without meals (table 2, 6, 10, and 17). At 12:55 PM, the last table was served. At 12:40 PM, resident interview (R80) and her family member on table 10 revealed that the food is always late. The family member stated "you see, we have no food yet." At 12:59 PM, another resident family member stated that they do not have enough servers and food is always late. On 7/7/09 at 5:10 PM, observation of dinner service on the satellite 600 unit lounge revealed that two residents (R25 and R68) had not been served while everyone else was eating. The two residents' meal trays were observed on the delivery meal rack in the lounge. Certified Nursing Assistant (CNA), E13, interview revealed that the staff needed to finish feeding the resident she was feeding before she could start feeding the residents waiting on either end of a table or on	**F 362**	1. No residents were affected by this practice. 2. The 600-wing dining room will no longer be used for resident meal service, and those residents will move to the Satellite dining room to ensure more staff for feeding residents and observation. Upon review of documentation provided to survey team it was acknowledged that the "Meal Times" schedule is reflective only of onset of meal service not the entire meal service period. The posted policy has been corrected to reflect this as well. (see attached) 3. An in-service will be provided to nursing staff on proper feeding practices and techniques. Dining Services staffing changes have been made and Dining Room Captain's have been identified to ensure enough properly trained wait staff are available at all meal times. 4. The charge nurses will monitor both dining rooms during each meal service for compliance and review the meal consumption records In addition, the Dining room schedule is being monitored by the Director of Dining and the Executive Chef as well. Realignment of positions took place on 8/10/09. The schedule changes and realignment of duties ensure that between the Director, Chef and Captains two supervisory level personnel are present at both lunch and dinner in the Main Dining Room to monitor service. This ensures adequate staffing to be available (see attached). **8/23/09**	

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	085043	A. BUILDING _____ B. WING _____	07/13/2009

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F 362	Continued From page 21 the side. Staff E13 stated that the resident's trays were on the rack covered so their food would stay hot. Two additional staff members were feeding residents in the 600 unit lounge. Observation of dinner service in the main dining room on 7/9/09 at 5:35 PM, revealed that a table of four residents (table 11) had not been served dinner while the rest of the residents in the room were finishing their meals and most tables were eating dessert (cookies). Resident at table 16 (R79) was served her meal at 5:39 PM. When asked residents at one of these tables why they were not eating yet, the residents stated they were still waiting for their meals and one said "look, other resident are getting their desserts". Within minutes of talking to the residents, their food plates were finally brought to the table. An interview with the facility Food Service Director (E9) on 7/14/09 stated that they need to make adjustments to their staffing schedules, so that they have enough people working during meals to serve residents in a timely manner.			
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:		**F 371** Example #1 1. No residents were affected by this practice 2. Corrective action was taken immediately to insure that all items running through the dishmachine were properly sanitized by installing an Ecosan sanitizing solution dispenser to the dishmachine. American Kitchen, our contracted repair company, was called on 7/7/09. They came out the same day and conducted an evaluation of the dish machine unit. Repairs were made to the booster unit on 7/20/09, including the installation of a new thermostat and new high-limit switch. On 7/15/09 and a new water board was installed and the final rinse gauge cam assembly and wash tank thermostat were replaced. (See attached Work Order reports from American Kitchens) 3. Dining Services staff were in-serviced on 7/22/09 (see attached training records) by the Ecolab representative regarding the proper procedure for engaging the sanitizer if the operating temperature of the dishmachine unit is not adequate. In addition, Dining Services staff was also in-serviced on 7/22/09 (see attached in-service training records) that dishmachine temperatures are to be checked and recorded daily by the dishmachine operator. If the temperatures are too low, staff has been trained to notify management immediately so that appropriate corrective actions can be taken.	

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F 371	Continued From page 22 Based on observations and interviews in the dietary area on 7/6/09, and 7/9/09, it was determined that the facility failed to prepare, serve and store food under sanitary conditions. Findings include: 1. On 7/9/09 at 12:10 PM, observations of the hot-water temperature dishwasher unit in the kitchen revealed that the wash cycle gauge was reading 135 degrees Fahrenheit and the rinse cycle gauge was reading 135F. These temperatures should be 150 degrees and 180 degrees respectively, if the unit is operating properly. A test strip to confirm the proper temperature inside the unit was used and it did not turn black to show that the unit was measuring the proper temperatures to sanitize the dishes. The facility and surveyor thermometers were then used to measure the highest internal temperature of the unit at the dish surfaces and read 135 degrees Fahrenheit. 2. On 7/9/09 at 12:30 PM, a dietary food service employee was asked to confirm the presence of a sanitizing agent in a three compartment pot sink in the kitchen using a test strip. Sanitizer was not detected. 150-400 PPM concentration is required to sanitize dishes at this three-compartment sink based on the manufacturer's label on the bottle of the quaternary sanitizer. Additionally, a three-compartment dairy sink was observed in use for cleaning pots and a test strip was used to detect the concentration of the sanitizer. No sanitizer was detected in the quaternary solution. The staff was in-serviced on the spot by the food service director (E9) for testing the sanitizer and for not using the dairy sink for washing pots.	F 371	4. AM and PM Supervisors are checking the dishmachine operating temperature logs twice daily to insure that temperatures are being checked, recorded and corrective action is taking place when necessary. **7/22/09** Example #2 1. No residents were affected by this practice 2. Contents of the dairy sink from the morning meal were immediately emptied and refilled with clean sanitizer solution. The sanitizer solution was checked to make sure it was at the proper concentration. Ecolab performed a service call on 7/23/09 to check the solution strength of the sanitizer solution for both the meal and dairy sinks. (see attached Record of Service call). The Ecolab representative discovered that the solution strength was not up to the proper level of concentration and made the appropriate change to the dispenser. 3. The solution strength is checked, logged, and monitored three times per day. Dining Services staff were in-serviced on this procedure on 7/22/09 (see attached in-service training records). 4. Effective July 2009, an Ecolab representative will conduct a monthly inspection of all chemical dispensing units to insure they are operating properly. A full report of the inspection, including any corrective action that was performed and any recommendations will be given to the Director of Dining Services so that it can be reviewed and appropriate follow up action, if necessary, can be initiated. AM and PM Supervisors are checking the Sanitizer solution logs three times a day to insure that concentrations are being checked, recorded and corrective action is taking place when necessary. **7/22/09**	

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F 371	Continued From page 23 3. On 7/6/09 at 7:45 AM and 7/9/09 at 12:11 PM, utensils such as forks, spoons, knives on the ready-to-use storage rack in the kitchen were observed stacked un-inverted, uncovered, and with the food contact area exposed to contamination. The utensils were stored in a high traffic area by the dishwasher area in the kitchen. 4. On 7/9/09 at 12:13 PM, two dietary staff hand sinks hot water temperature in the kitchen and the dietary staff bathroom hand sink hot water temperatures were detected at about 84 degrees Fahrenheit. This is lower than 110F required by the 1999 food code regulations. 5. On 7/6/09 at 7:45 AM and 7/9/09 at 12:15 PM, observation of the kitchen ice cream freezer revealed frost on the sides of the freezer and on top of ice cream containers. On 7/6/09 at 7:45 AM, the reach-in dairy refrigerator in the kitchen was observed leaking onto the dairy products (creamers) of the refrigerator. On 7/9/09 at 12:15 PM, the refrigerator was still leaking but food products had been moved to the side and a tray had been placed to collect the water leaking into this area. 6. On 7/9/09 at 12:33 PM, one male dietary staff in the kitchen was observed walking towards the steam table with a potato chip bag and was observed eating potato chips from the bag and then observed serving chips from the bag onto resident plates. Additionally, two dietary staffs were observed serving food at the steam tables such as placing breads on resident plates, opening jars, opening doors to dining area, and touching clothing without washing hands. The	F 371	Example # 3 1. No residents were affected by this practice 2. Dining Services staff was in-serviced on 7/20/09 with regard to the proper procedure for storing utensils, as per policy. (see attached policy and in-service training records) 3. All new hires will be in-serviced regarding this Policy during the new hire orientation process (see attached FoodHandler On-the-Job Orientation and Training Record) 4. Line Supervisors monitor and check utensils before and after each meal service. Management will inspect compliance with Policy during daily rounds and during the department's Monthly Sanitation Audit (see attached). **7/23/09** Example #4 1. No residents were affected by this practice. 2. Staff was immediately directed to not use the hand sink identified, and to use the hand sink located in kitchen next to the steam table on the meat side. A foam hand sanitizer solution has been placed at this sink as well. 3. The Community Works Department inspected the plumbing system on 7/7/09. Based on their findings, an outside plumbing contractor was hired to modify the plumbing in order to insure the availability of 110 degree hot water at all sinks in the kitchen at all times. This work will be completed by 8/23/09. 4. Temperatures will be checked three times a day by supervisors and management and recorded. Maintenance will be informed immediately if temperatures are not at least 110 degrees. **8/23/09**	

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F 371	Continued From page 24 staff kept the same pair of gloves and did not replace gloves or wash their hands to remove the potential for contamination. On 7/6/09 at 12:25 PM, one male dietary staff (Staff 1) was observed cleaning up and picking up dirty plates from one resident table, returning to kitchen steam table and dining area with clean dishes filled with food and placing on resident tables. On 7/6/09 at 12:29 PM, a second staff (Staff 2) was observed opening jars and doing different tasks in the kitchen (to serve food for lunch) at the steam table with the same gloves without washing hands or replacing gloves, and proceeding to serve food plates at the dining tables. Additionally, dietary staff (Staff 1) tossed food in the garbage can in the kitchen and was observed returning to the steam table and continuing to handle food and then returning to dining tables without washing hands or replacing gloves. 7. On 7/6/09 at 7:30 AM, one staff member was observed without a hair net while another was improperly wearing a hair net only covering half of the head. On 7/9/09 at 12:30 PM, three dietary staffs had hair nets on half way and were not covering their hair completely. Director of Dining Services interview (E9) confirmed these findings.	F 371	Example #5 1. No residents were affected by this practice 2. Ice cream freezer was removed from premises on 7/20/09 3. Ice cream is now properly stored in walk-in freezer 4. Dining Service Management will monitor compliance regarding the proper storage of food during daily rounds and during the department's Monthly Sanitation Audit. **7/20/09** Example # 5 (continued) 1. No residents were affected by this practice 2. Food products stored on the side of the refrigeration unit in question were immediately relocated to the opposite side of the refrigeration unit. Foy Refrigeration was contacted on 7/7/09. On 7/7/09 Foy's technician conducted a service call and the refrigeration unit was repaired (see attached work report). 3. Staff are responsible to check the refrigeration unit daily and if there are any issues, a work order is to be created by the AM or PM Supervisor and turned into the maintenance department immediately 4. AM and PM Supervisors are monitoring compliance as part of their daily checklist during rounds **7/20/09**	
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug			

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F 371	Continued From page 24 staff kept the same pair of gloves and did not replace gloves or wash their hands to remove the potential for contamination. On 7/6/09 at 12:25 PM, one male dietary staff (Staff 1) was observed cleaning up and picking up dirty plates from one resident table, returning to kitchen steam table and dining area with clean dishes filled with food and placing on resident tables. On 7/6/09 at 12:29 PM, a second staff (Staff 2) was observed opening jars and doing different tasks in the kitchen (to serve food for lunch) at the steam table with the same gloves without washing hands or replacing gloves, and proceeding to serve food plates at the dining tables. Additionally, dietary staff (Staff 1) tossed food in the garbage can in the kitchen and was observed returning to the steam table and continuing to handle food and then returning to dining tables without washing hands or replacing gloves. 7. On 7/6/09 at 7:30 AM, one staff member was observed without a hair net while another was improperly wearing a hair net only covering half of the head. On 7/9/09 at 12:30 PM, three dietary staffs had hair nets on half way and were not covering their hair completely. Director of Dining Services interview (E9) confirmed these findings.	F 371	Example # 6 1. No residents were affected by this practice 2. Employees identified have been educated and counseled. All staff was immediately in-serviced on proper food handling procedures as well as hand washing and glove use per policy (see attached) 3. Subsequent in-services were held and management team has been monitoring compliance 4. Continued training and checks by AM and PM Supervisors are in place to monitor the effectiveness of the in services and policy. **7/22/09** Example # 7 1. No residents were affected by this practice 2. Employees involved have been educated and counseled. All staff was in serviced on appropriate application of hair nets (see attached in-service sign in sheet) 3. Policy was reviewed on how and when hairnets are to be worn 4. Management is monitoring the proper use of hairnets daily **7/20/09**	
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug			

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F 431	Continued From page 25 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to lock the med cart twice during the medication pass observation. Findings include: Review of the facility policy entitled, "Medication Administration-General Guidelines" stated, " ...B. Administration ... During the administration of		**F 431** 1. No residents were affected by this practice. 2. Nurse E 18 was individually educated and counseled on this practice. 3. Nurses will attend a Medication Pass in-service including Infection Control by 8/23/09. Each nurse will complete a Clinical Care competency test by 8/23/09 (see attached). 4. Nursing administration will complete random medication pass monitoring utilizing the Medication Administration audit tool. (see attached) This will be done on an annual basis and the results submitted to the QA meeting. **8/23/09**	

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F 431	Continued From page 26 medications, the medication cart is kept closed and locked when out of sight of the medication nurse... No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and ... must be inaccessible to residents or others passing by." 1a. During the Med Pass observation on 7/12/09 at 9:40 AM, the med nurse, E18 was preparing meds for R98. The call bell alarmed in room #105A. E18 left her med cart on the opposite side of the hall, unattended, unlocked, and out of her view with 16 blister packages of medications sitting on top of the pull-out shelf of the cart. These meds were easily accessible to any passing residents. Additionally, E18 left the MAR (Medication Administration Record) opened with R98's personal information displayed. 1b. During the Med Pass observation on 7/12/09 at 10:05 AM, the med nurse, E18 was preparing meds for R85. E18 left the cart parked outside room #103 in the hall while she washed her hands in the resident room #101. The med cart was once again left out of E18's view, unlocked, unattended and accessible to residents or others passing by. During an interview on 7/12/09 at 11:10 AM, E18 stated, "I never lock it." adding that she parks the cart in front of the resident's room. It was pointed out to her that when the cart was left unlocked, it was out of her sight, left unattended and was accessible to other residents or others passing by. E18 agreed. The facility failed to safeguard medications and failed to maintain privacy of R98's MAR during the med pass observations on 7/12/09.	F 431		

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F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews it was determined that the facility failed to ensure that a dressing treatment to a pressure ulcer for one out of 40 census sampled residents (R16) was administered in a manner to prevent infection. Findings include: Resident R16 was initially admitted to the facility on 09/10/2008 with a reentry date of 05/18/2009 following a hip fracture. Additional diagnoses for this resident included abdominal pain, constipation, urinary tract infection, hypertension and dementia. The MDS (Minimum Data Set) dated 05/25/2009 stated that R16 was cognitively impaired and was totally dependent upon staff for all ADLs (activities of daily living). This MDS (5 day Medicare assessment) and the 14 day Medicare assessment dated 05/28/2009 MDS stated there were no pressure ulcers present. The MDS (30 day Medicare assessment) dated 06/07/2009 stated the resident had 4 (should have been a 1) stage 4 pressure ulcers. The	F 441	**F 441** 1. Resident has been monitored for signs and symptoms of infection with none evident. 2. Nurse E 12 was provided one on one education on the proper procedure of the treatment. 3. American Medical Technology will conduct a wound care in-service on 8/18/09. A Clinical Care competency test will be completed by all nurses by 8/23/09 and will include wound care practices (see attached) 4. The SWIFT team, along with wing charge nurses will conduct wound rounds with charge nurses and observe treatments/procedures on a weekly basis. The findings will be included in the report at the monthly QA meeting. **8/23/09**	

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F 441	Continued From page 28 nurses's note dated 06/03/2009 and timed 8 PM noted on right heel a 5 cm by 4 cm dark blister with skin intact. The doctor was notified and among the orders dated 06/03/2009 included treatment with skin prep to the right heel, elevate heels from bed and to use heel protectors. The 07/01/2009 physician orders repeated these orders. On 07/10/2009 at 9:40 AM an observation was made of (E12) the nurse providing the treatment to R16's pressure ulcer. The nurse with a gloved hand applied the first skin prep to the pressure ulcer. Then with this same gloved hand the nurse picked up the used skin prep from the floor. The nurse then with out washing hands or changing gloves applied a second new skin prep to the right heel. Interview with the (E12) nurse caring for R16 on 7/13/09 at 7:00 AM reviewed the incorrect technique used during application of the skin prep.	F 441	**F 445** 1. The temperature has been raised to the required of at least 160 degrees 2. Modifications to the system will be made to enable the water heater to continuously maintain a minimum of 160 degrees by 8/2309 3. The daily Laundry inspection sheet and the Housekeeping AM and PM sheet will have added the Laundry water heater temperatures (see attached) 4. A sub-committee report dedicated to Regulatory issues will be added to the Quality Assurance agenda to ensure that regulation changes are monitored **8/23/09**	
F 445 SS=D	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation of the laundry area on 7/9/09, and staff interviews, it was determined that the facility failed to handle and distribute linens so as to prevent the spread of infection. Findings include: On 7/9/09 at 9:20 AM, observations of the laundry			

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F 445	Continued From page 29 hot water boiler tank temperature gauges revealed the hot water supply temperature to the washers at 140 degrees Fahrenheit versus the required temperature of a 160 degrees Fahrenheit minimum. Maintenance staff (E8) interview confirmed this finding.	F 445		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: The Milton and Hattie Kutz Home

DATE SURVEY COMPLETED: July 13, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced QIS annual survey was conducted at this facility from July 6, 2009 through July 13, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 87. The survey sample totaled 91 residents, which included 40 census residents, 20 admission residents and 31 stage 2 residents.	
3201	**Nursing Home Regulations For Skilled Care**	
3201. 6.0	**Services To Residents**	
3201. 6.1	**General Services**	
3201. 6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.**	
	This requirement is not met as evidenced by:	**Cross-refer to F 254, F 281, F 309, F 314, F 362 and F 441**
	Cross-refer to CMS 2567-L survey date completed 7/13/09, F254, F281, F309, F314, F362 and F441.	**Date of Completion – 8/23/09**

Provider's Signature _____ Title Executive Director Date 8-14-09

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3201. 6.4	**Therapy Services**	
3201. 6.4.2	**Upon completion of a specialized service, the therapist shall communicate to the interdisciplinary team in writing any maintenance program to be included in the care plan.** Cross-refer to CMS 2567-L survey date completed 7/13/09, F318.	**Cross-refer to F 318**
3201. 6.5	**Nursing Administration**	**Date of Completion– 8/23/09**
3201. 6.5.6	**A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.** **This requirement is not met as evidenced by:**	

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	Cross-refer to CMS 2567-L survey date completed 7/13/09, F279.	**Cross-refer to F 279**
3201. 6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.**	**Date of Completion – 8/23/09**
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 7/13/09, F272, and F280.	**Cross-refer to F 272 and F 280**
		Date of Completion – 8/23/09
3201. 6.9	**Housekeeping and Laundry Services**	
3201. 6.9.1	**The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed	

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	7/13/09, F253.	
3201. 6.11	**Medications**	**Cross- refer to F 253**
3201. 6.11.1	**Medication Administration**	**Date of Completion – 8/23/09**
3201. 6.11.1.6	**An individual resident may self-administer medications upon the written order of the physician, following determination by the interdisciplinary team that this practice is safe. The facility shall establish policies and procedures pertaining to the security of self-administered medication.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed 7/13/09, F281 Example 1.	**Cross-refer to F 281, Example 1**
3201. 7.3	**Facility Systems Requirements**	**Date of Completion – 8/23/09**
3201. 7.3.1	**Water Supply and Sewage Disposal**	
3201. 7.3.1.3	**Hot water accessible to residents shall not exceed 110° F.**	
	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L survey date completed	

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	7/13/09, F323.	
3201. 7.5	**Kitchen and Food Storage Areas**	**Cross-refer to F 323**
3201. 7.5.1	**Facilities shall comply with the Delaware Food Code.**	**Date of Completion – 8/23/09**
	This requirement is not met as evidenced by:	
	Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-401.11, 2-402.11, 2-402.11, 4-501.11 , 4-501.114, 4-703.11, 4-903.11 and 5-202.12 of the State of Delaware Food Code. Findings include:	
	2-401.11 Eating, Drinking, or Using Tobacco.*	
	(A) Except as specified in ¶ (B) of this section, an employee shall eat, drink, or use any form of tobacco only in designated areas where the contamination of exposed food; clean equipment, utensils, and linens; unwrapped single-service and single-use articles; or other items needing protection can not result.	
	(B) A food employee may drink from a closed beverage container if the container is handled to prevent contamination of:	

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	(1) The employee's hands; (2) The container; and (3) Exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 7/13/09, F371, Example (6). 2-402.11 Effectiveness. (A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils and linens; and unwrapped single articles. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 7/13/09, F371, Example (7). 4-501.11 Good Repair and Proper Adjustment.	Cross-refer to F 371, Example 6 Date of Completion – 7/22/09 Cross-refer to F 371, Example 7 Date of Completion – 7/20/09

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	(A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) Equipment components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. This requirement is not met as evidenced by: Cross-refer to CMS 2567-L survey date completed 7/13/09, F371 Example (5) 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization, Temperature, pH, Concentration, and Hardness.* A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at exposure times specified under ¶ 4-703.11(C) shall be listed in 21 CFR 178.1010 Sanitizing solutions, shall be used in accordance with the EPA-approved manufacturer's label use instructions, and shall be used as follows: (C) A quaternary ammonium compound	**Cross-refer to F 371, Example 5** **Date of Completion – 7/20/09**

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	solution shall: **(1) Have a minimum temperature of 24°C (75°F),** **(2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 7/13/09, F371 Example (1) **4-703.11 Hot Water and Chemical.*** **After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in:** **(C) Chemical manual or mechanical operations, including the application of sanitizing chemicals by immersion, manual swabbing, brushing, or pressure spraying methods, using a solution as specified under § 4-501.114** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 7/13/09, F371, Example (2). **4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles.**	**Cross-refer to F 371, Example 1** **Date of Completion – 7/22/09** **Cross-refer to F 371, Example 2** **Date of Completion – 7/22/09**

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	(B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored: **(1) In a self-draining position that allows air drying; and** **(2) Covered or inverted.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 7/13/09, F371, Example (3). **5-202.12 Handwashing Facility, Installation.** **(A) A handwashing lavatory shall be equipped to provide water at a temperature of at least 43°C (110°F) through a mixing valve or combination faucet.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 7/13/09, F371, Example (4). **For on-site laundry processing, the facility shall:** **Provide a room under negative air pressure for**	**Cross-refer to F 371, Example 3** **Date of Completion – 7/23/09** **Cross-refer to F 371, Example 4** **Date of Completion – 8/23/09**

DELAWARE HEALTH AND SOCIAL SERVICES
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	receiving, sorting, and washing soiled linen. Washers must be supplied with hot water of 160° F. **This requirement is not met as evidenced by:**	
3201. 7.6.3	Cross-refer to CMS 2567-L survey date completed 7/13/09, F445.	**Cross-refer to F 445** **Date of Completion – 8/23/09**
3201. 7.6.3.1	**Nursing staffing** **(a) Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** **This requirement is not met as evidenced by:**	**16 Del C., § 1162** 1. **No residents were affected by this practice** 2. **Name badges were distributed to all personnel immediately as soon as identified** 3. **Employees have been advised to request a name badge from the Receptionist or supervisor should theirs be missing. Name badges will be checked by department heads or charge nurses at the beginning of each shift.** 4. **Dining Services AM and PM Supervisors and Nursing Administration will monitor uniform to include wearing name badges.** **Date of Completion – 8/14/09**
16 Del. C., § 1162.	Based on observation throughout survey, it was determined that the facility failed to have staff wear identification nametag that prominently displayed their names and titles. Findings include: Five staff persons, four were dietary staff and one was a certified nursing assistant in second shift, were observed not wearing their identification name tags.	

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